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# NAVAL SCHOOL OF HEALTH SCIENCES



## **CERTIFIED CLINICAL SUPERVISOR**

***CCS***  
***(Reciprocal)***

## ***CERTIFICATION PORTFOLIO***

*(Rev 12-02)*

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## PREFACE

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Many professions have used Portfolios as a collection of visual samples of a candidate's work, e.g. sketches, pictures, or sculpture. However, when applied to the counseling field, portfolios contain descriptive information. This type of Portfolio indicates the candidate's job-related knowledge and skills, and usually includes the following components:

- **Work Experience**
- **Formal Training and Education**
- **Structured Experiences**

This document has been designed and developed to be compatible with and an introduction to the International Certification & Reciprocity Consortium/ Alcohol and Other Drug Abuse (IC&RC/AODA) International Certification Standards. The following sections contain sample forms and application materials necessary for reciprocal certification or recertification.

## BACKGROUND

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The Certified Clinical Supervisor (CCS) certification is the most advanced Navy/Marine Corps certification available to date. Navy and Marine Corps personnel certified at this level are expected to be the role models for other counselors in military treatment. They have demonstrated expertise not only in the alcohol and other drug counseling arena, but also have begun to master the knowledge and skills necessary to supervise interns and other certified counselors in the chemical dependency clinical setting. IC&RC/AODA considers individuals certified at the CCS level as meeting minimum international entry-level standards.

This credential is reciprocal to other IC&RC/AODA boards. Reciprocity, however, does not mean "right to practice." Individual states or countries, despite being member boards of IC&RC/AODA, may require additional education or testing prior to allowing an individual the right to practice as an AODA supervisor in their jurisdiction.

The U.S. Navy Certification Board (USNCB), as a member of IC&RC/AODA, has jurisdiction only over those individuals working for the U.S. Navy or Marine Corps. Once certified, an individual may maintain their certification with the USNCB, only as long as they remain on active duty, or for civilians, remain working for the Department of the Navy.

# ELIGIBILITY REQUIREMENTS

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## **CCS - Certified Clinical Supervisor (Reciprocal)**

- \_\_\_ 1. ADC II Certification or hold a specialty substance abuse credential in another professional discipline in the human services field at the master's level or higher.
- \_\_\_ 2. Verification of five years/10,000 hours of counseling experience as an AODA Counselor.
- \_\_\_ 3. Verification of 2 years/4,000 hours of clinical supervisory experience in the AODA field. These 2 years may be included in the 5 years of counseling experience and must include the provision of 200 contact hours of face to face clinical supervision.
- \_\_\_ 4. Verification of 30 hours of didactic training in clinical supervision. This must include Training in each of the following areas: Assessment/Evaluation; Counselor Development; Management/Administration; and Professional Responsibilities.
- \_\_\_ 5. Adhere to the Code of Ethics for Substance Abuse Clinical Supervisors through a signed statement.
- \_\_\_ 6. Favorable recommendation by Chain of Command and Clinical Supervisor/Preceptor.
- \_\_\_ 7. Pass IC&RC/AODA Clinical Supervisor written examination.
- \_\_\_ 8. **Re-Certification** - Nine (9) CEH's must be earned every three years and must be clearly documented as relating to the four performance domains. Additionally the applicant must maintain their primary substance abuse certification (e.g., ADC II, specialty substance abuse credential.)

## **INSTRUCTIONS**

1. All pages numbered CCS – 1 through 18 in this portfolio must be completed for initial certification. If applying for **recertification**, read each page to ensure applicability.
2. All forms must be submitted as originals, **NO** duplicates, facsimile, or electronic submissions will be accepted.
3. It is highly encouraged to maintain copies of all submissions.
4. Mail all applications to the U.S. Navy Certification Board at:  
NSHS NDACS  
ATTN: CERTIFICATION OFFICE  
NAVSUBASE BLDG 500  
140 SYLVESTER ROAD  
SAN DIEGO, CA 92106-3521
5. The Competency Assessment Form should be completed by the Clinical Preceptors/Supervisors who supervise your work as a drug and alcohol supervisor/counselor prior to your certification. **It is your responsibility** to ensure that you have the form completed by any supervising individual who may be leaving your command before you are ready to submit your Portfolio.
6. The USNCB will return incomplete applications via the chain of command.
7. Hours used to qualify for initial certification or recertification:
  - a. Must be specific and identifiable to AODA Clinical Supervision.
  - b. May also be used toward recertification requirements for ADC II.

## **ADDENDUM**

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These are supplemental forms designed to support your development as an addictions professional. It is recommended that you familiarize yourself with these resources prior to beginning the initial application process:

- A. Reciprocity Application
- B. International Application

## **GLOSSARY**

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<b>ADC</b>	Alcohol and Drug Counselor
<b>AODA</b>	Alcohol and Other Drug Abuse
<b>ATF</b>	Alcohol (Addiction) Treatment Facility
<b>ATOD</b>	Alcohol, Tobacco and Other Drug
<b>BUMED</b>	Bureau of Medicine and Surgery
<b>CCS</b>	Certified Clinical Supervisor
<b>CPM</b>	Case Presentation Method
<b>HQMC</b>	Headquarters U.S. Marine Corps
<b>IC&amp;RC/AODA</b>	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse
<b>LIP</b>	Licensed Independent Practitioner
<b>MTF</b>	Military Treatment Facility
<b>NAADAC</b>	National Association of Alcohol and Drug Abuse Counselors
<b>NDACS</b>	Navy Drug and Alcohol Counselor School
<b>SARP</b>	Substance Abuse Rehabilitation Program

***The forms contained in this Portfolio are originals.  
Please make sufficient copies prior to use!***

***All entries must be legible***

## **PRIVACY ACT STATEMENT**

***THIS IS NOT A CONSENT FORM TO RELEASE CERTIFICATION INFORMATION  
PERTAINING TO YOU.***

1. Authority for the collection of information including Social Security Number (SSN).

*Applicable sections of United States Code 301 and Departmental Regulations*

2. Principal purposes for which this information is intended to be used.

*This form provides you the advice required by The Privacy Act of 1974. The information will facilitate and document your certification process. The Social Security Number (SSN) is required to identify and retrieve certification records.*

3. Routine uses.

*The primary use of this information is to provide, plan and coordinate certification of personnel who serve in clinical roles as Alcohol and Drug Counselors. Other possible uses are to compile statistical data, conduct research, determine suitability for assessment as a Alcohol and Drug Abuse Counselor, and conduct authorized investigations.*

4. Whether disclosure is mandatory or voluntary and the effect on the individual of not providing the information.

*The requested information is voluntary. If not furnished, certification of the individual will not be accomplished and the individual will not be authorized to serve in clinical positions as a Alcohol and Drug Abuse Counselor.*

Your Signature merely acknowledges that you have been advised of the forgoing. If requested, a copy of this form will be provided to you.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*All entries must be legible*



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## **REFERENCES**

Current Immediate Supervisor Name: \_\_\_\_\_  
Last First MI

Rank/Rate: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

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(If not currently working as a supervisor/counselor, list most recent Director and Preceptor information below)

Facility Director Name: \_\_\_\_\_  
Last First MI

Rank/Rate: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

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Preceptor Name \_\_\_\_\_  
Last First MI

E-mail address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

## **Personal Reference (REQUIRED)**

(Someone who has worked with you and/or can vouch for your Clinical Supervisory Competency)

Name: \_\_\_\_\_  
Last First Middle

E-mail address: \_\_\_\_\_

Work Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Phone: Comm: (\_\_\_\_\_) \_\_\_\_\_ DSN: \_\_\_\_\_

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## **EDUCATION**

### **Instructions.**

- **Submit copies** of all certificates, diplomas, or transcripts.
- Course descriptions are required for all courses that have not been pre-approved by the U.S. Navy Certification Board.
- Supporting documentation is **REQUIRED!!**
- This form should also be used to document all continuing education hours for recertification purposes.

1. For Initial CCS certification - Have you completed 30 hours of education/training in clinical supervision? **Yes** ☐ **No** ☐  
(If Yes, insert documentation immediately following this page. If No, then STOP and complete the 30 hours training regimen prior to submitting this application..)

2. Have you earned a degree or certificate from a college or university during this certification period? **Yes** ☐ **No** ☐

School name: \_\_\_\_\_ Location \_\_\_\_\_

Type of Degree/Certificate \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Area of Concentration \_\_\_\_\_

Hours: \_\_\_\_\_

3. List all AODA clinical supervision courses/continuing education completed during this certification period.

**(Start with the most recent)**

A. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_

Hours: \_\_\_\_\_

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**(Duplicate and renumber this page if additional sheets are necessary)**

B. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

C. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

D. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

E. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

F. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

G. Institution/conference/presenter name: \_\_\_\_\_

Course title: \_\_\_\_\_

Start Date \_\_\_\_\_ End Date: \_\_\_\_\_

Location \_\_\_\_\_ Hours: \_\_\_\_\_

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## **CURRENT SUPERVISOR/COUNSELOR CERTIFICATIONS**

1. Are you certified at the reciprocal level as an AODA counselor (ADC II)? **Yes** ☐ **No** ☐  
(If No go to #2)

**Certification Board/Agency Name:** \_\_\_\_\_  
(e.g. U.S. Navy Certification Board (USNCB))

Cert. title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
(e.g. ADC II)

(If certified by agency other than USNCB then include the following)

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_  
Number, Street, Suite Number

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

(If certified as an ADC II with the USNCB and have completed the above information, go to #3)

2. Do you hold a specialty substance abuse credential in another professional discipline in the human services field at the master's level or higher? **Yes** ☐ **No** ☐

Which professional discipline? \_\_\_\_\_

**Credentialing Board/Agency Name:** \_\_\_\_\_  
(e.g. American Psychological Association, American Psychiatric Nursing Association)

Credential title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_  
Number, Street, Suite Number

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

3. If you hold any other AODA certification, complete the following

**Certification Board/Agency Name:** \_\_\_\_\_  
(e.g. U.S. Navy Certification Board (USNCB))

Cert. title: \_\_\_\_\_ Cert # \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
(e.g. CCS)

(If certified by agency other than USNCB then include the following)

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_  
Number, Street, Suite Number

Telephone: (\_\_\_\_) \_\_\_\_\_ Email address (if known): \_\_\_\_\_

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## **PROFESSIONAL/VOLUNTEER WORK EXPERIENCE**

### **NOTES:**

- A normal work year is calculated to be 2,080 hours minus any leave or extended TAD periods.
- The USNCB recognizes no more than 40 hours per week when calculating work experience.
- It is the USNCB policy to scrutinize any application that is submitted with the bare minimum five years experience.

### **Military Work Setting**

1. Are you currently working as a full time AODA supervisor/counselor in a military treatment facility?

Yes ☐

No ☐

(If no go to # 2)

What is the Facility name? \_\_\_\_\_

What is your position title? \_\_\_\_\_

Describe the clinical supervisory responsibilities of your position? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Clinical Supervisory Responsibilities:

Start Date: \_\_\_\_\_  
mo/day/yr

End Date: \_\_\_\_\_  
mo/day/yr

2. List all other military AODA counselor/supervisory work experience:

Facility Name: \_\_\_\_\_ Position: \_\_\_\_\_

Describe clinical responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Clinical Supervisory Responsibilities:

Start Date: \_\_\_\_\_  
mo/day/yr

End Date: \_\_\_\_\_  
mo/day/yr

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Facility Name: \_\_\_\_\_ Position: \_\_\_\_\_

Describe clinical responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Clinical Supervisory Responsibilities: \_\_\_\_\_ Start Date: \_\_\_\_\_  
mo/day/yr

End Date: \_\_\_\_\_  
mo/day/yr

3. If currently working in a military treatment facility have the Facility Director complete the following section:

**Facility director verification of work experience hours.**

Through direct observation, review of fitness/evaluation reports, or other documentation of work experience, I certify that the applicant has completed \_\_\_\_\_ hours of work as an AODA clinical supervisor and that at least 200 of these hours has been in the provision of face to face clinical supervision. Certified on this date: \_\_\_\_\_.

Director name:(print)\_\_\_\_\_ Signature \_\_\_\_\_

**4. Applicant's affidavit of military work experience hours.**

I certify that I have worked in the above treatment setting(s) providing direct counseling services to AODA clients and meet the minimum requirement of five years counseling experience. I further attest that I have 4,000 hours clinical supervisory experience and that at least 200 hours has been in the provision of face to face clinical supervision.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

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**(Duplicate and renumber this page if additional sheets are necessary)**

### **Civilian Work Setting**

**Note:** If applying for recertification and/or no longer working in a military treatment facility list any civilian or volunteer work in this section. If none, go to the Code of Ethics on page CCS - 10

5. List all paid or volunteer work experience. Each entry requires supporting documentation on agency letterhead.

Agency/Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Start Date: \_\_\_\_\_ mo/day/yr End Date \_\_\_\_\_ mo/day/yr Is this Paid or Volunteer? \_\_\_\_\_

Describe, in detail, what duties you perform at this job: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many hours a week, on average, do you perform these duties? \_\_\_\_\_ Weekly Work Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you attached documentation that supports all of the above? **Yes** ☐ **No** ☐

(If No then the above work experience will not be counted for certification/recertification purposes.)

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Agency/Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Number, Street, Suite Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ - \_\_\_\_\_

Start Date: \_\_\_\_\_ mo/day/yr End Date \_\_\_\_\_ mo/day/yr Is this Paid or Volunteer? \_\_\_\_\_

Describe, in detail, what duties you perform at this job: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many hours a week, on average, do you perform these duties? \_\_\_\_\_ Weekly Work Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Have you attached documentation that supports all of the above? **Yes** ☐ **No** ☐

(If No then the above work experience will not be counted for certification/recertification purposes.)

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## **Code of Ethics for Substance Abuse Clinical Supervisors**

### **I. Code of Ethics**

This code of ethics applies to Alcohol, Tobacco and Other Drugs (ATOD) Substance Abuse Professionals who are credentialed as Certified Clinical Supervisors (ATOD/CCS) and applies to their conduct during the performance of their clinical duties as supervisors.

### **II. Supervision**

Supervision is a disciplined and defined clinical activity. It has a parallel, but linked relationship to teaching, consulting, administering and researching. It is a necessary, significant and meaningful aspect of the delivery of competent, humane, ethical and appropriate services to clients/consumers.

### **III. Rules of Conduct**

These ethics constitute the standards an ATOD/CCS should maintain. These ethics shall be used as an aid in resolving an ambiguity which may arise in the application and interpretation of these rules.

### **IV. Competence**

An ATOD/CCS shall limit practice to areas of competence in which proficiency has been gained through education or documentable experience or through the awarding of a reciprocal professional certification or licensure. An ATOD/CCS shall accurately represent areas of competence, education, training, experience and professional affiliations, in response to responsible inquiries, including those from appropriate boards, the public, supervisees and colleagues. An ATOD/CCS shall aggressively seek out consultation with other professionals when called on to supervise counseling situations outside their realm of competence. An ATOD/CCS will refer supervisees to other competent staff when they are unable to provide adequate supervisory guidance to the supervisee.

### **V. Client Welfare and Rights**

The primary obligation of an ATOD/CCS is to train substance abuse counselors so that they respect the integrity and promote the welfare of their clients. ATOD/CCS should have supervisees inform clients that they are supervised and that details of their treatment can and will be discussed or reviewed with a supervisor. Any audio or video taping of a client/counsumer's treatment must be authorized in writing. An ATOD/CCS should make supervisees aware of clients' rights, including protecting clients' rights to privacy and confidentiality in the counseling relationship and the information resulting from it. Clients also should be informed that their right to privacy and confidentiality will not be violated by the supervisory relationship. Records of the supervisory relationship, including interview notes, test data, correspondence, the electronic storage of these documents, and audio and video recordings are to be treated as confidential materials. Written permission for use of these materials outside of the supervisory session must be granted by the client. An ATOD/CCS is responsible for monitoring the professional actions of their supervisees as well as their failure to take appropriate action. An ATOD/CCS is responsible for the presentation of adequate training for all supervisees in the area of transference, dual relationships, cultural sensitivity and professional deportment.



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## **VI. Professional Behavior**

Due to the unique scope of practice substance abuse counselors provide, CCS must monitor the following behaviors of their staff and themselves:

- A.** The arrest for the possession or use of any illegal drug, narcotic or mood altering substance.
- B.** The use of intoxicants and/or non physician prescribed and monitored mood altering substance when engaged in professional pursuits.
- C.** The conduct of intimate, personal and/or business relationships of any kind with any patient or their families. This applies to all clients. A supervisee should have all relationships of this kind reviewed. An ATOD/CCS should consult with an objective peer when this issue is raised.
- D.** The sponsoring of any active or discharged patient or family member by counselors or supervisors who are members of Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Al Anon, Etc.

## **VII. Supervisory Role**

Inherent and integral to the role of clinical supervisor are responsibilities for monitoring client welfare, ensuring compliance with relevant legal and professional standards of service delivery, monitoring clinical performance and professional development of supervisees and evaluating and certifying current performance and potential of supervisees for academic, screening, selection, placement, employment and credentialing purposes.

- A.** An ATOD/CCS should have ongoing training in supervision.
- B.** An ATOD/CCS should pursue professional and personal continuing education activities to maintain their ATOD/CCS credential and to improve their supervisory skills. Competency in the Four Performance Domains of ATOD Clinical Supervision must be maintained.
- C.** An ATOD/CCS must maintain professional decorum and standards. Unprofessional behaviors as outlined in item VI. above will not be tolerated.
- D.** An ATOD/CCS should make their supervisees aware of professional and ethical standards and legal responsibilities of the counseling profession. In the absence of agency or state policy, the industry standards of ethical behavior should be explained to the supervisee.
- E.** An ATOD/CCS should strive to enable supervisees to be competent, autonomous, professional, judicious, aware of limitations, and to become future supervisors if that is an appropriate career goal.
- F.** Procedures for contacting the supervisor, or an alternative supervisor, to assist in handling crisis situations should be established and communicated to supervisees.
- G.** Actual work samples via audio, counselor report, video or observation should be part of the regularly scheduled supervision process.
- H.** Supervision is maintained through regular face-to-face meetings with supervisee in group or individual sessions.
- I.** An ATOD/CCS should provide supervisees with ongoing feedback on their performance.
- J.** An ATOD/CCS who has multiple roles (e.g. teacher, clinical supervisor, administrator, etc.) with supervisees should avoid any conflict of interest caused by these disparate roles. The supervisees should know the limitations placed on the ATOD/CCS and the supervisor should share supervision when appropriate.
- K.** An ATOD/CCS should not participate in any form of sexual contact with supervisees. Supervisors should not engaged in any form of social contact or interaction which would compromise the supervisor-supervisee relationship. Dual relationships (including outside consultancy, partnerships, nepotism, etc.) with supervisees that might impair the supervisor's objectivity and professional judgment should be avoided and/or the supervisory relationship terminated.

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- L.** ATOD/CCS are not to sexually harass, make sexual advances, or engage in sexual contact with supervisees.
- M.** ATOD/CCS shall not use the supervision process to further personal, religious, political or business interests.
- N.** ATOD/CCS should not endorse any treatment that would harm a client either physically or psychologically.
- O.** An ATOD/CCS should not establish a psychotherapeutic relationship as a substitute for supervision. Personal issues should be addressed in supervision only in terms of the impact of these issues on clients and on professional functioning.
- P.** An ATOD/CCS should never supervise past or current clients, or the family members of clients, who are now staff members.
- Q.** An ATOD/CCS should model appropriate use of supervision themselves for problem solving and practice reviewing.
- R.** An ATOD/CCS must be straight forward with supervisees about observed professional and clinical limitations of the supervisee. These concerns must be clearly documented and shared with the supervisee.
- S.** An ATOD/CCS who is a member of Alcoholics Anonymous, Narcotics Anonymous, Al Anon, etc., should never sponsor a supervisee.
- T.** An ATOD/CCS should not endorse a supervisee for certification or credentialing if the supervisor has documentable proof of impairment or professional limitations that would interfere with the performance of counseling duties in a competent and ethical manner. The presence of any such impairment should begin with a process of feedback and remediation whenever possible so that the supervisee understands the nature of the impairment and has the opportunity to remedy the problem and continue with his/her professional development.
- U.** An ATOD/CCS should incorporate the principles of informed consent and participation; clarity of requirements, expectations; roles and rules; and due process and appeal, into the establishment of policies related to progressive discipline.
- V.** An ATOD/CCS must be able to integrate the 13 Core Functions of Substance Abuse Clinical Competency into their theoretical and supervisory approach. A clear understanding of the 49 Global Criteria is essential.
- W.** An ATOD/CCS ensures the professional quality of the programs that their supervisees participate in.
- X.** An ATOD/CCS should be an active participant in quality assurance and peer review.
- Y.** The supervision provided by an ATOD/CCS must be provided in a professional and consistent manner to all supervisees regardless of age, race, national origin, religion, physical disability, sexual orientation, political affiliation, marital or social or economic status. When a supervisor is unable to provide non-judgmental supervision a referral to an appropriate supervisor with a complete explanation of the supervisee must be made.

Name: \_\_\_\_\_  
Print

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
mo/day/yr

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## COMPETENCY ASSESSMENT FORM

(Do not complete this section for recertification)

### EVALUATOR QUALIFICATIONS

- This section must be completed by an individual who meets the definition and requirements as a Clinical Preceptor and/or Clinical Supervisor as defined in the current certification instruction.
- All evaluators must have had responsibility for supervising or training the applicant for a minimum of 90 days.

Candidate Name: \_\_\_\_\_  
Last First Middle

Facility name and location where applicant is/was being observed: \_\_\_\_\_

### Preceptor Information:

Preceptor: \_\_\_\_\_  
(print or type) Name Title Affiliation / Credentials

E-mail address: \_\_\_\_\_

Length Supervised by Preceptor: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
months mo/day/yr mo/day/yr

Preceptor verification of length of supervision: \_\_\_\_\_  
Signature Date

### Clinical Supervisor Information

Clinical Supervisor: \_\_\_\_\_  
(print or type) Name Title Affiliation / Credentials

E-mail address: \_\_\_\_\_

Length Supervised by Clinical Supervisor: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
months mo/day/yr mo/day/yr

Supervisor verification of length of supervision : \_\_\_\_\_  
Signature Date

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***All entries must be legible***

## **PERFORMANCE DOMAINS OF THE CERTIFIED CLINICAL SUPERVISOR:**

Certified Clinical Supervisor (CCS) competence is based on demonstrated proficiency in four performance domains identified in the following tables. The certification process is one measure of competence. Clinical Supervisors are not required to be experts in all these domains, but as a candidate for CCS the applicant must be able to demonstrate a minimum level of competence in each. Remember that although many of the functions and tasks may overlap, depending on the nature of the clinical supervisor's practice, each represents a specific aspect of supervision skills.

### **Table Instructions:**

- **The evaluator, preferably the Clinical Preceptor, should take into account all previous supervisor evaluations when completing these tables.**

Place an 'X' in the appropriate Box. Use a **1 as the LOWEST** rating, **5 as the HIGHEST**.

<b>Performance Domains</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>N/O</b>
<b>I. ASSESSMENT AND EVALUATION</b>						
Task 1. Assess the supervisee's experience with and/or knowledge of the field of alcohol and other drug abuse, social and behavioral science, and Twelve Step philosophy and tradition, by interview, questioning, exploration, and/or discussion in order to determine the supervisee's strengths and weaknesses..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 2. Assess supervisee temperament, leadership style, interpersonal strength/weakness, and reactions to stress within the work setting by use of interview, observations, and assessment instruments in order promote supervisee growth..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 3. Analyze supervisee performance of tasks related to the twelve core functions in order to identify levels of performance by interview, direct observation, review of case records, and use of evaluation tools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 4. In order to become familiar with the supervisee's levels of clinical functioning, explore his or her ability to utilize various therapeutic approaches by direct, ongoing observation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 5. Evaluate the supervisee's strengths and weaknesses by interview, observation, and feedback solicited from other sources in order to make appropriate work assignments and to formulate a plan for the supervisee's ongoing development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II: COUNSELOR DEVELOPMENT</b>						
Task 1. Build with the supervisee a developmental framework for a supervisory relationship through the use of assessment activities, case presentation, demonstration, and dialogue, for the purpose of facilitating supervisee development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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*All entries must be legible*

Performance Domains	1	2	3	4	5	N/O
<b>II: COUNSELOR DEVELOPMENT (Cont.)</b>						
Task 2. Promote a career development process with the supervisee through the use of mutual planning, assessment activities, and motivational techniques, in order to stimulate a desire for continuing personal and professional growth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 3. Work with the clinical staff to facilitate clinical teamwork behaviors by using observational tools, staff discussion, demonstration, and reading/writing tasks, for the purpose of improving and maintaining clinical staff resource utilization and effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 4. With supervisee participation, develop and implement a clinical training and education program based on an assessment of the supervisee's learning needs in order to operationalize clinical training and educational practices for the purpose of strengthening the supervisee's clinical competence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 5. Provide direct clinical supervision to supervisees, using a variety of supervisory methods, in order to build supervisee's clinical skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III: MANAGEMENT AND ADMINISTRATION</b>						
Task 1. Assist in developing quality improvement guidelines, implementing those procedures and standards with staff involvement in a continuing quality improvement plan, in order to monitor and upgrade clinical performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 2. Monitor compliance with federal, state, and Navy/Marine Corps regulations, implementing supervisee's and client's rights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 3. Evaluate and monitor agency policies and procedures using accreditation standards to ensure compliance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 4. Plan and coordinate the activities of supervisees to promote effective management in order to maintain clinically effective programming, through the review of daily schedules, consultation, knowledge of onsite and community resources, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 5. Meet with new staff to orient them to all program components and professional expectation in order to enable new staff to adhere to the program's performance standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 6. Identify and assess program needs utilizing available mechanisms in order to formulate a plan for enhancing clinical services and program development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 7. Coordinate consultation services with supervisee utilizing additional resources for the purpose of providing continuity of quality care for clients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 8. Recommend, in accordance with agency policy and procedures, the employment and termination of clinical staff by participating in review, selection, and evaluation processes in order to retain quality clinical staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Performance Domains</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>N/O</b>
<b>IV: PROFESSIONAL RESPONSIBILITY</b>						
Task 1. Participate actively in professional organizations to model and encourage professional involvement by the supervisee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 2. Promote, maintain, and safeguard the best interests of the supervisee by adhering to established codes of ethics in order to encourage high standards of conduct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 3. Pursue personal and professional development by participating in related professional educational activities in order to improve supervisory competence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 4. Strive to maintain or improve personal, physical and mental health by participating in activities which promote professional effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 5. Recognize the uniqueness of the individual supervisee by gaining knowledge about personality, culture, lifestyle, personal feelings, and other factors in order to influence the supervisee in the process of his/her development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Task 6. Subscribe to federal, state, local, and agency (Navy/Marine Corps) rules/regulations and other legal and liability guidelines regarding alcohol and other drug abuse treatment by following appropriate procedures in order to protect supervisee rights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### **Supervisor/Preceptor Comments: (Required)**

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\_\_\_\_\_  
 Evaluator Name, (signature) Date: \_\_\_\_\_  
 mo/day/yr

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## **CERTIFICATION TESTING INFORMATION**

### **DANTES/EDUCATION OFFICER AFFIDAVIT**

Only the DANTES Testing Officer may administer the written CCS examination. Instructions for administering the examination, will be forwarded to the DANTES Test Control Office. The examination may **ONLY** be administered on the dates set by IC&RC/AODA. Both you and the DANTES Test Control Officer (TCO) will receive notification of the test date via official correspondence. Please have the DANTES TCO complete the following form.

Testing Official Name: Mr./Ms./Mrs.  
(Please Print Legibly) (circle one) First MI Last

Physical Shipping Address: \_\_\_\_\_  
(for UPS/FED-EX delivery)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -

Telephone: (\_\_\_\_) \_\_\_\_\_ DSN: \_\_\_\_\_

FAX: (\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

I certify that I am the designated DANTES Testing Official and that I will follow established procedures in order to protect the certification examination against compromise. I will notify the USNCB if there are any discrepancies in the testing procedures.

Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alternate DANTES Contact information : Please provide alternate point of contact information, if applicable.

Alternate Testing Official Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

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**Recertification - Have the Supervisor and Facility Director  
endorsement sections completed *ONLY* if currently working as a  
Clinical Supervisor**

**SUPERVISOR ENDORSEMENT**

Please have your immediate supervisor write a brief endorsement, commenting on the applicant's skills and readiness to become certified, or remain certified, at the CCS level. Attach additional sheet, if necessary.

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Supervisor signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FACILITY/PROGRAM DIRECTOR ENDORSEMENT**

Please have your immediate Facility Director, Program Director, or Department Head write a brief endorsement, commenting on the applicant's skills and readiness to become certified, or remain certified, at the CCS level.

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Director's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMMANDING OFFICER'S ENDORSEMENT**

"I \_\_\_\_\_ **DO / DO NOT** Recommend  
Commanding Officer's Name (Circle One)

\_\_\_\_\_ for Certification as an Certified Clinical Supervisor(CCS)  
Applicant's Full Name

Please enter any comments as desired. \_\_\_\_\_

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\_\_\_\_\_ Date  
Commanding Officer's Signature



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**Application for Supervisor/Counselor Reciprocity**

**HOW TO APPLY FOR RECIPROCITY:**

1. Complete this application and sign the release and authorizations.
2. Make a copy of this application to keep for your records.
3. Attach a copy of your current member board certificate (your application will be denied without this).
4. Enclose a check/money order for \$100.00 (\$90.00 if you are certified by USA/USN) to IC&RC
5. Mail complete application packet to IC&RC – 6402 Arlington Blvd, Ste 1200, Falls Church, VA 22042  
Phone (703) 294-5827 Fax: (703) 875-8867

Downloadable application: <http://www.icrcaoda.org/reciprocity/ReciprocityApplicationAODA.pdf>

The IC&RC office will review your application and contact both certification boards involved in the reciprocity process. You will receive confirmation from your new certification board within 4 to 6 weeks.

**PLEASE PRINT OR TYPE:**

Name: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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**RELEASE FORM - - This form expires 60 days from date of signature.**

I, \_\_\_\_\_ (your name) hereby authorize the IC&RC/AODA member board in \_\_\_\_\_ (Old state) to release all information regarding my qualification for Certification to the IC&RC/AODA member board in \_\_\_\_\_ (new state).

I, \_\_\_\_\_ (your name) also authorize the IC&RC/AODA member board in \_\_\_\_\_ (Old State) to verify, to their knowledge, whether or not I have received a reprimand, suspension, or revocation of my certificate for professional violation of the state code of conduct and/or ethics by that or any other board **at any time** during certification.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I do \_\_\_\_\_ do not \_\_\_\_\_ wish to remain certified in both states.

If you have a Clinical Supervisor certification and wish to transfer it at no additional cost, please indicate so (if yes, then include a copy of certificate as well) YES \_\_\_\_\_ NO \_\_\_\_\_ N/A \_\_\_\_\_

**Authorization and Waiver**

**I hereby authorize the request and release of all records and/or information in any way relating to my certification, qualification or experience as an alcohol, drug, or AODA counselor, I understand that this includes, but is not limited to, oral or written contracts with members of the IC&RC/AODA, similar licensing or certifying agencies or another state, former employers and/or other persons or organizations having pertinent information. This is a waiver of my privilege that may otherwise exist in respect to the disclosure of such information.**

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### ***IC&RC/AODA International Certificate Application/Renewal***

As a CCS certified by an IC&RC member board, (USNCB), you are eligible to receive an international certificate! This credential identifies you as an Internationally Certified Clinical Supervisor (ICCS).

By applying, you grant permission for your name, address, and phone number to be listed in the Directory of International Alcohol and Drug Abuse Counselors/Supervisors to be published at a later date by the IC&RC/AODA.

To apply for certification, or renewal, download and complete the application located at this web address: <http://www.icrcaoda.org/appdocs/ICCSApplication.pdf>

The cost is \$1.00 per month for the months remaining on your current certification. Make a check payable to IC&RC/AODA. (**Do Not** make the check out to the Navy or USNCB or it will be returned to you with your application)

Mail the application with the check or money order to:

NSHS NDACS  
ATTN: CERTIFICATION OFFICE  
NAVSUBASE BLDG 500  
140 SYLVESTER ROAD  
SAN DIEGO, CA 92106-3521